Financial Agreement

This is an agreement between Mariana Conant, DDS, LLC, as creditor, and the Patient/Debtor named on this form. In this agreement the words "you," "your," and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we," "us," and "our" refer to Mariana Conant, DDS, LLC. By executing this agreement, you are agreeing to pay for all services that are received.

Missed Appointment Fee: Patients who do not show up for an appointment, or cancel with less than 24 hours notice will be charged a $50 fee. This fee must be paid before a new appointment is scheduled.

Payment options if you have no dental insurance:

1.You may pay by cash, check, HSA card or credit card (MasterCard, Visa, Discover or Amex) when treatment is rendered; 2.Payment plans are available from Care Credit and Compassionate Finance.

Payment options if you have dental insurance:

1.You are required to pay your deductible and any out-of-pocket portions when treatment is rendered by cash, check, HSA card or credit card (MasterCard, Visa, Discover or Amex); 2.Payment plans are available from Care Credit and Compassionate Finance.

Insurance is a contract between you and your insurance company. We are NOT a party to this contract. We will bill your insurance company as a courtesy service to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. We do our best to estimate your out of pocket cost, however, this is just an estimate. A balance may still remain after your insurance pays according to plan benefits. We do not base your diagnosed treatment on your insurance coverage; instead we base it on your clinical needs and desires. Quoted fees can only be extended for a period of six (6) months from the date your treatment is diagnosed.

Payments: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the due date.

Charges to Account: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service. Failure to keep your account current prevents us from providing you with additional dental services, except for dental emergencies prepaid by cash.

Finance Charge: A finance charge will be imposed on each item of your account which has not been paid within thirty (30) days of the time the item was added to the account. The **FINANCE CHARGE** will be computed at the rate of one and a half percent (**1.5%**) per month or an **ANNUAL PERCENTAGE RATE** of eighteen (**18%**) percent. The minimum Finance Charge is **$5.50**.

The Financial Agreement continues on the back side of this page.

Patient Name: _____

Patient's (or Legal Guardian's) Signature: _____ Date: _____

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance charge, if any, and any payments or credits applied to your account during the month. Payments are due the same day service is rendered.

Credit History: You give us permission to check your credit and employment history and to answer questions about your credit experience with us. We have the option to report your account status to any credit reporting agency such as a credit bureau.

Returned Checks: There is a **$30** NSF fee for any checks returned by the bank.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyers' fees which we incur plus all court costs. In case of suit, you agree the venue shall be in Fairfield County, Connecticut.

Waiver of Confidentiality: If this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the treatment you received at our office may become a matter of public record.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. The parent authorizing treatment for a child will be the parent responsible for subsequent charges. If the divorce decree requires the other parent to pay for any treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Transferring of Records: You will need to request in writing if you want to have copies of your records sent to another doctor or organization. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. Payment of the bill remains the patient's responsibility. We cannot bill your attorney for charges incurred due to a personal injury case.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Brickwalk Dental
1305 Post Rd Ste 200
Fairfield, CT 06824
P:203.255.5999
F:203.255.9972